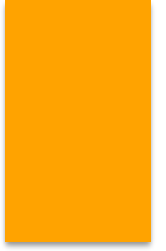




CENTER FOR  
ELDER  
LAW &  
JUSTICE



# **2021 Medicaid Basics & Current Trends**

Presentation By: Kelly Barrett Sarama, Esq.  
[ksarama@elderjusticenyc.org](mailto:ksarama@elderjusticenyc.org) | 716.853.3087, Ext. 229



# Disclaimer

- **Please note:** The following content is for informational purposes only. It is not to be interpreted as legal advice and the information contained is not necessarily applicable to your specific case.



# Welcome

- ▶ Introduction
- ▶ Overview of our agency
- ▶ Topics
  - ▶ Medicare
  - ▶ Medicaid/MLTC
  - ▶ Common MLTC Legal Issues
  - ▶ Pooled Trusts – very brief introduction
  - ▶ Questions

A yellow sticky note is pinned to the right side of the slide with a red pushpin. The text on the note is written in a bold, black, sans-serif font.

**Important  
Information**



# Medicaid and Medicare

- ▶ Medicaid is generally limited to those with low income and minimal assets.
- ▶ Medicare is generally limited to those 65+, unless you have ESRD, ALS, or have received SSD for a minimum of 2 years.
- ▶ If you qualify for both, you are considered “dually eligible.”



# Medicare

- ▶ **Traditional**

- Part A: Hospital Coverage
- Part B: Doctor Coverage – essential services
- Does not cover vision, hearing, dental

- ▶ **Medicare Advantage**

- Part C = A + B, administered by a private plan
- Can provide coverage beyond the scope of traditional Medicare

- ▶ **Part D → Drug coverage**

- Extra Help

There is a special program called the Low Income Subsidy (LIS) which helps with Medicare Part D cost sharing. LIS is also known as "Extra Help." The Social Security Administration administers LIS -- you don't apply through your Part D plan.



## Medicare Savings Program (MSP)

Funded by the State Medicaid program, **Medicare Savings Programs (MSPs)** help eligible individuals meet some or all of their cost-sharing obligations under Medicare. *See* N.Y. Soc. Serv. L. § 367-a(3)(a), (b), and (d). There are three separate MSP programs, the Qualified Medicare Beneficiary (QMB) Program, the Specified Low Income Medicare Beneficiary (SLIMB) Program and the Qualified Individual (QI) Program.

NOTE: You can divert excess income into a Pooled Trust in order to qualify for an MSP program **WITHOUT** applying for full Medicaid benefits. If you do receive Medicaid and divert your excess income into a pooled trust, you likely qualify for an MSP. If you are not automatically screened, you should speak to your LDSS.



# Medicare Savings Programs (MSP)

## 2021 New York gross monthly income limits

## 2021 New York asset limits

Program	Individuals	Couples	Individuals	Couples
QI	\$1,469	\$1,980	No limit	No limit
SLMB	\$1,308	\$1,762	No limit	No limit
QMB	\$1,094	\$1,472	No limit	No limit
Medicaid	\$1,004	\$1,320	\$15,900	\$23,400

These income limits are based on the 2021 federal poverty level (FPL), and include a standard \$20 disregard. You may qualify even if your income is slightly higher. Ask a Medicaid counselor about whether you can subtract certain expenses from your income.



# Resource and Income Limits 2021

Community Medicaid: Disabled, Aged (65+) Blind Applicants/Recipients (Non-MAGI):

- ▶ Resources: (includes savings/checking accounts, CDs, stocks, other liquid savings):
  - **Living Alone \$15,900**
  - **Couple \$23,400**
  
- ▶ Income:
  - **Living Alone \$884**
  - **Couple \$1,300**



# Spousal Impoverishment Protections

**Spousal Impoverishment Protections:** The spouse of a nursing home resident, an MLTC recipient, or a Waiver Program Participant may keep a reasonable level of income and resources to live on while still permitting Medicaid payment for the Medicaid recipient's care.

- **Income Allowed Monthly for Community Spouse: \$3,259.50.**
- **Resources: Community Spouse may have up to the greater of \$74,820 or one-half of the couple's total combined assets up to \$130,380.**
- This total includes the Community Spouse's own resources in his/her own name, plus any of the Medicaid-recipient Spouse's own resources that exceed \$15,900, plus any of their joint resources. The spouse must actually transfer his/her own individual and their joint resources that exceed the individual resource limit to the Community Spouse.



# Income Spend Down

When an individual or couple has income in excess of their monthly limit, they can still be eligible for Medicaid with a Spenddown (DAB category ONLY). You have several options to meet this limit:

1. Submit unpaid Medical bills equal to the excess income to DSS;
2. Pay the excess income amount directly to DSS or MLTC plan; or
3. A disabled individual may divert excess into a *Supplemental Needs Trust/Pooled Trust* to deposit “excess” income monthly. Money put into the trust is exempt from Medicaid, so the spenddown is reduced or eliminated.

**\*NOTE:** A married couple with only one Medicaid recipient may not use a pooled trust and spousal impoverishment budgeting together – they must choose one or the other.



# Spending Down Excess Resources

11

**If you have excess resources**, you can become eligible for Medicaid by spending the excess. Here are some recommended ways of spending down:

- ▶ Household items or expenses
- ▶ Pre-need Funeral Agreement and/or burial fund
- ▶ Purchases for Fair Market Value



## WARNING: Penalties for Transfers of Assets

Upon application for Medicaid coverage of long-term institutionalized care, **any resources** held by the applicant or spouse at any time during the period 60 months prior to the application, known as the “look-back period,” **must be accounted for in order for the applicant to become eligible for Medicaid.** Receipts for large purchases must be saved and should be available if requested by DSS. **Any transfer of an asset for less than fair market value (gift), made within the look-back period, will be presumed to have been made for the purpose of qualifying for Medicaid and will likely result in a period of ineligibility for Medicaid coverage of long-term care.**



A large, bold, red 3D-style text "NEW!" with a black outline, set against a yellow starburst background. The graphic is centered within a white rectangular box.

Beginning October 1, 2020\*, there will be a 2.5-year look-back period (30 months) for community-based long-term care applications. Based on current guidance, we believe this will begin to be implemented in January 2022, and the look-back will go back to October 1, 2020. For example, if you apply in January 2022, your look-back will be for only 15 months, not 2.5 years. DOH still needs to issue further guidance.

\*Note: Cannot be implemented until State of Emergency is no longer in effect.



# Managed Long Term Care Plans

- MLTC plans are insurance plans that are paid a monthly capitated rate by the New York Medicaid program to approve and provide Medicaid home care and other long-term care services to people who need long-term care because of a long-lasting health condition or disability.
- The MLTC plans decide how many hours you may receive and arrange for the care by a network of providers. They also approve, manage and pay for other long-term care services.



# Who Must Enroll in MLTC Plans?

- ▶ As of December 2014, any Medicaid recipient:
  - ▶ over the age of 21
  - ▶ who is eligible for both Medicaid and Medicare (dually eligible)
  - ▶ who requires over 120 days of skilled nursing care\*

**\*Note:** From 2014 until July 2020, this type of Medicaid covered long-term home care and institutionalized nursing home care. In 2018, New York State decided to carve out nursing home care from MLTC and transition it back to fee-for-service Medicaid. The implementation was delayed until July 2020. **Happening now**, nursing home residents in MLTC plans should have already received disenrollment letters from their plans and they will be automatically enrolled in fee-for-service Medicaid.



## First-Time Enrollment in a MLTC Plan

1. Apply for Medicaid at your local DSS.
2. Contact NY Medicaid Choice, the enrollment broker, to schedule a “conflict-free assessment” to determine long-term care eligibility. Contact 1-888-401-6582 for assistance.
3. When approved: member has 60 days to choose a plan or they will be automatically assigned one.
4. You will be assessed again by the MLTC plans you want to pursue in order to create your personalized care plan.



## Important Changes to Medicaid Enrollees' Appeal and Fair Hearing Rights – Effective May 1, 2018

- ▶ Enrollee is entitled to written notice at least 10 days before the plan says it will reduce or stop any services (this is unchanged).
- ▶ **EXHAUSTION REQUIREMENT:** Enrollee **MUST** first request an **Internal Plan Appeal** and receive a **Final Adverse Determination BEFORE** requesting a State Fair Hearing. Enrollee has **60 days** to make this request.
- ▶ Enrollee may request an Internal Plan Appeal orally via telephone but must follow up an oral request with a written request by mail or fax. Enrollee must give written authorization to anyone requesting an appeal on their behalf, or the appeal may not be processed.



## Important Changes to Medicaid Enrollees' Appeal and Fair Hearing Rights – Effective May 1, 2018

18

- ▶ **Aide Continuing** must be requested **twice** during the appeals process – you must request aide continuing directly from the plan before the proposed reduction or denial goes into effect – essentially, Enrollees have approximately 10 days to request aide continuing at this stage. Once you receive a Final Adverse Determination from the Plan, you must again request aide continuing from OTDA when you request a State Fair Hearing. This request must also occur within 10 days of the Final Adverse Determination, even though you have 120 days to request a Fair Hearing.
- ▶ **Enrollees have 120 days to request a State Fair Hearing** from the date of the Final Adverse Determination. **Only Exception:** if Plan fails to timely respond to Internal Plan Appeal, Enrollee may request a State Fair Hearing without receiving a Final Adverse Determination from the Plan.



# Changes to MLTC Plan Eligibility and Enrollment – Effective April 1, 2018, Implemented July 2020

19

- MLTC plans are now essentially only for individuals applying to receive homecare services. There is limited coverage of nursing home stays, but only if the stay is temporary.
- **For a new long-term nursing home Medicaid applicant, the type of Medicaid to apply for is Fee-for-Service Medicaid.** If you are already on an MLTC plan when you enter the facility, you will be transitioned into Fee-for-Service Medicaid after 3 months of permanent institutionalization (or a long-term stay).
- After initial MLTC enrollment, enrollee has a very short window to switch MLTC plans. From there, the **enrollee is locked into their plan for 12 months.**



# Major Medicaid Issues in WNY

20

- Staying in the Community
- **Transitioning from a Rehab/SNF back to the Community**
- Budgeting
- Environmental Mods
- **Staffing Issues:**
  - Major Issue in rural areas more than the city of Buffalo
- Major Issue in suburbs with limited access to public transportation
- Why are there staffing issues? Money and transportation, Covid-19



# Issues to Watch for Due to Recent Changes

21

- Confusion about appeal rights
- Plans sending old notices describing old appeal rights
- Even more staffing issues due to contracting limitations and Covid-19
- Difficulty transitioning home from SNF due to disenrollment from MLTC
- Plan transition issues – plans will likely drop out and beneficiaries will have to transition into a new MLTC Plan
- Problems with response to internal appeals





# What is a Pooled Trust?

A Pooled Trust is a tool that can be used to enhance the quality of life for individuals with disabling conditions. The trust can be used to purchase additional items and services not adequately covered by governmental benefits. The Pooled Trust must be used for the benefit of an individual with a disabling condition and the expenditures made on behalf of that person should supplement, not replace their government benefits.



# What are the Eligibility Requirements?

The individual must be disabled per social security standards and have Medicaid

- ▶ physically or mentally impaired, injured, or incapacitated. You are considered disabled under Social Security rules if:
  - ▶ You cannot do work that you did before;
  - ▶ They decide that you cannot adjust to other work because of your medical condition(s); and
  - ▶ Your disability has lasted or is expected to last for at least one year or to result in death.

# Questions?

## CONTACT INFORMATION:

KELLY BARRETT SARAMA

SUPERVISING ATTORNEY, CENTER FOR ELDER LAW & JUSTICE

(716) 853-3087, EXT. 229

[KSARAMA@ELDERJUSTICENY.ORG](mailto:KSARAMA@ELDERJUSTICENY.ORG)